4467 Old Branch Ave, Suite 101, Temple Hills MD 20748 ⁎ Phone: 301-358-6155 ⁎ Fax: 301-423-1440 ⁎ www.porterarehab.com

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ***Portera Rehabilitation.*** to furnish medical care and treatment to________________________________ considered necessary and proper in diagnosing or treating his/her physical condition.

Parent/Guardian/Responsible Party________________________________ **Date ________________**

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to ***Portera Rehabilitation***. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Parent/Guardian/Responsible Party________________________________ **Date ________________**

FINANCIAL POLICY STATEMENT

We bill your invoice carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that that arrangement for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***Portera Rehabilitation***.

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be responsible for the total amount of charges for services rendered to you.

Portera Rehabilitation verifies benefits as a courtesy to you. However, Portera Rehabilitation does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/ co-insurance benefits or benefit plans.

When you pay by check, you expressly authorize ***Portera Rehabilitation***, if your check is dishonored or returned for any reason, to be charged to your account. You will responsible for the amount of the check plus a returned check fee of $37.00.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court cost, collection agency fees, and attorney fees.

Information Privacy: ***Portera Rehabilitation*** will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of this notice may change with time and we will always post the current notice on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

I, the undersigned:
( ) have insurance coverage by __________________________, and authorize direct payment from my insurance carrier to Portera Rehabilitation. Note: You are responsible for knowing your coverage benefits. Portera Rehabilitation will make every effort to inform you if a supply or service is not covered by your insurance

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____	____________	__________________________________	_________
Parent/Guardian/Responsible Party	**Date**	**Center Representative/Witness**	**Date**